



**BREAST DIAGNOSTIC AND FOLLOW-UP FORM**  
**ALABAMA BREAST AND CERVICAL CANCER**  
**EARLY DETECTION PROGRAM (ABCCEDP)**

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Tracking Number (required)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Last) (First) (Middle) (mm) (dd) (yyyy)

Social Security Number: \_\_\_\_\_ Referring Clinic Provider: \_\_\_\_\_

Physician/Surgeon: \_\_\_\_\_ Phone No: \_\_\_\_\_ Appointment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Reason for Referral: \_\_\_\_\_ Mammogram/US Result \_\_\_\_\_ Date Performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance Status:  No Insurance  Underinsurance  Insured Billed to Medicaid: \_\_\_\_\_ Yes

Repeat CBE/Surgical consultation:  
 Result:  Refused/Not done Date Performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 No intervention/routine follow-up Provider: \_\_\_\_\_  
 Short term follow-up: \_\_\_\_ mos.  
 Biopsy/FNA recommended

Fine Needle Aspiration/Cyst Aspiration  
 Result:  Refused/Not done Date Performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 No fluid or tissue obtained Provider: \_\_\_\_\_  
 Non-suspicious  
 Suspicious for neoplasm

Biopsy Result:  Refused/Not done  
 Surgical  Hyperplasia  
 Stereotactic  Other benign changes  
 Core Needle  Lobular Carcinoma In Situ (LCIS)\* Date Performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Carcinoma in situ\* Provider: \_\_\_\_\_  
 Invasive breast cancer\*  
 \*Please contact your Area Screening Coordinator as soon as diagnosis of cancer is known.  Normal breast tissue  
 Other: \_\_\_\_\_

Other Tests Performed Date Performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 If yes, specify: \_\_\_\_\_ Provider: \_\_\_\_\_

Final Diagnosis  
 Breast Cancer not diagnosed  
 Ductal Carcinoma In Situ (DCIS) Date Performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Lobular Carcinoma In Situ (LCIS)  
 Invasive Breast Cancer

Status of Diagnostic Work-up  
 Work-up completed  Work-up pending  
 Lost to follow-up  Irreconcilable\* Date Performed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Work-up refused  
 \* If the provider refers for short-term follow-up instead of following guidelines.

Treatment Status  
 Initiated  Refused  
 Pending  Not indicated  
 Lost to follow-up  Updated (follow-up information)

Treatment (not paid by Alabama Breast and Cervical Cancer Program)  
 Mastectomy Treatment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Lumpectomy Treatment Provider: \_\_\_\_\_  
 Re-excision of the biopsy site  
 Other

Case Management Needed:  Yes Contact your area screening coordinator

Further Treatment required:  
 Referred to: \_\_\_\_\_ Phone No: \_\_\_\_\_ Appt. Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ABCCEDP does not pay for treatment, but patient may be eligible for Medicaid Treatment Program.